Momentum Medicine Plus *Weightloss*

Consent For Medical Weight Loss Treatment

I,________________________________ hereby authorize Dr. Juan Carlos Cornejo, a medial physician, to provide medical care regarding treatment to assist me in my weight reduction effort and coexisting medical conditions. This may involve but not be limited to history taking, in-office testing, physical examination, and additional laboratory testing.

I understand that my weight management treatment may consist of but not limited to specific diet plans, such as a low carbohydrate diet; recommendations for behavior modification techniques, including prescribed regular exercise regimens; and possibly the use of over-the-counter, supplemants, and prescription medications, e.g. appetite suppressants. I understand that I may be prescribed medications for medical conditions other than those relating to my weight management according to general medical practice standards.

I understand that if medications are prescribed, especially medications for weight control such as appetite suppressants, their duration of use and prescribed dosage and frequency may exceed or vary with those indicated in the package insert or those set forth by the FDA which suggest usage on short term basis (12 weeks). It has been explained to me that these medications have been used safely and successfully in private and academic medical practice with appropriate monitoring for periods and at dosing and frequency regimens exceeding or at variance with those recommended. Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most medications, that there could be serious side effects (as noted below).

I understand this authorization is given with the knowledge that the use of the appetite suppressants, for any time, or more so if used more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common side effects of appetite suppressants include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious, fatal, or possibly disabling. I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify the Momentum Medicine Plus staff and/or physician, as well as my primary care physician, immediately. Also if the problem is severe, I will go to the nearest emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, since these conditions are a contraindication to the use of appetite suppressants. I also agree not to take any other weight loss medications, other than those prescribed by the physicians of Momentum Medicine Plus. I further agree to inform the Momentum Medicine Plus staff of any changes in my medication or medical history. Also I understand it is recommended that **I can not drink caffeine such as regular coffee, tea, sodas, energy drinks with the diet appetite medications and that I will avoid alcohol** with the diet medications.

I understand that I have alternative treatment options, including but not limited to no treatment at all and weight management programs without prescription medications. I also understand that remaining overweight or obese puts me at greater risk for ill health. Some of the complications that may develop as a consequence of prolonged abnormal body weight are arthritis of the joints, especially weight-bearing joints such as hips, knees, feet and back, high cholesterol and triglycerides, high blood pressure, diabetes, vascular disease complicated by stroke, heart attack and abnormal heart rhythms, gallstones, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I also understand that compliance with the diet and exercise as instructed by the doctor is a vital component in the diet program in order to meet optimal results. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance. I understand that the success of weight management treatment depends on my active participation. I understand that the physcians at Momentum Medicine Plus cannot guarantee or assure treatment success or any definite outcome. I understand that obesity is considered a chronic condition that may require permanent changes in my eating habits and behavior to attempt success at treatment. I understand that I must follow the program as directed, in order to achieve weight loss. By consenting to treatment, I agree to pay, and full, for visits and charges incurred at each visit. I understand that these charges may or may not be covered by insurance and Momentum Medicine Plus does not provide or fill out claimant forms for insurance purposes. I also understand that no refunds are given out.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician's Signature:______________________________________ Date:_____/_____/2014

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

Patient's Signature: X____ Date:_____/_____/2014

(or person with authority to consent for patient)